

**Racial and Socioeconomic Differences in Abortion Attitudes from a Nationally
Representative South African Sample in 2013**

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Abstract

Safe abortion is a necessary prerequisite of the human rights to health and gender nondiscrimination, yet half of abortions globally are still unsafe—contributing to 13% of maternal mortality. In South Africa, abortion was legalized after Apartheid in 1996, but today an estimated 58% of abortions remain unsafe there and researchers have observed resurgence in abortion-related deaths since 2002. Preliminary evidence suggests Black African women of lower socioeconomic position, particularly those living with HIV, are at disproportionate risk of unsafe abortion-related complications and death. Poor access to safe services is often cited as the major barrier to safe abortion. While most researchers have attributed such limited access to abortion stigma, it remains unclear how prevalent negative abortion attitudes are in South Africa today, how those might have changed over time, or whether differences exist by race or socioeconomic position. The current study analyzes abortion attitudes collected in a nationally representative sample from the South African Social Attitudes Survey in 2013. First, the study investigates how prevalent negative abortion attitudes are in South Africa today. Then binary logistic regression models of negative abortion attitudes are used to calculate odds ratios for race, educational attainment, and household income. Binary logistic regression models are also estimated stratified by race and education level. Results suggest an important role of secondary and post-secondary education in addressing abortion stigma. Significant differences in abortion attitudes are noted by province but not by race.

Keywords: abortion attitudes, abortion stigma, South Africa, race, education, income, unsafe abortion

Introduction

Safe abortion has been identified as a necessary prerequisite of the human rights to health and nondiscrimination, yet unsafe abortion and social inequities therein remain critical global public health issues (Shah, Åhman, & Ortayli, 2014). Worldwide, half of all abortions are still conducted under unsafe conditions (e.g., by under-trained providers, in environments not meeting minimal medical standards, illegality) (Shah et al., 2014). Maternal health risks from safe abortion are negligible, but *unsafe* abortion causes 13% of all maternal mortality globally: 192 preventable deaths every day (Shah et al., 2014). Nearly all unsafe abortion deaths occur in less developed regions, with women in sub-Saharan Africa generally experiencing greatest risk as abortion is largely illegal in the region (Sedgh et al., 2012; Shah et al., 2014). While rates of unsafe abortion have slowly declined globally, they remain particularly high in sub-Saharan Africa (31 unsafe abortions per 1,000 women 15-44 years), where an estimated 90 women per 100,000 live births died in 2008 as compared to one woman in all developed regions combined (Åhman & Shah, 2011).

South African leaders legalized abortion after Apartheid in 1996, causing a dramatic 91% mortality decline from 425 deaths in 1993 to 40 in 2001 (R. Jewkes & Rees, 2005; Trueman & Magwentshu, 2013). Alarming, triennial maternal mortality reports since then have suggested resurgence in unsafe abortion deaths. Between the periods of 2002-2004 and 2011-2013, the number of “miscarriage” deaths (which includes both induced and spontaneous abortion) rose 62%— even as overall maternal mortality from HIV started to decline (National Committee for the Confidential Enquiries into Maternal Deaths (NCCEMD), 2006, 2014). Although not adequately documented in the literature, preliminary evidence suggests morbidity and mortality

from unsafe abortion continues to inequitably affect (Black) African¹ women of lower socioeconomic position (SEP) living with HIV (Constant, Grossman, Lince, & Harries, 2014; Cooper et al., 2004; Stevens, 2012; Trueman & Magwntshu, 2013; Drs. Deborah Constant, Susan Fawcus, Caitlyn Gerdts, Jane Harries, Judy Kluge, Eddie Mhlanga, and Neil Moran, personal communications, 2015). This gap likely reflects both theoretical and practical conditions: many researchers in post-Apartheid South Africa are philosophically opposed to continuing social categorization by race and there is, in turn, a dearth of race-specific quantitative data available for analysis (Bassett, 2000). In the context of such limitations, researchers have cautiously concluded that lower SEP and African women are more likely to terminate their pregnancies in public abortion clinics as compared to more affluent and White women who can afford higher quality abortion services in the private sector (Department of Health, Medical Research Council, & OrcMacro, 2007; Harries, Gerdts, Momberg, & Greene Foster, 2015; Trueman & Magwentshu, 2013). Similarly, Constant et al. (2014) found women who self-induced their abortion were marginally more likely to be African and unemployed. Trueman and Magwentshu (2013) also noted that women of lower SEP are more likely to utilize services in the informal abortion market. Finally, evidence suggests women living with HIV experience greater risk of unsafe abortion: as much as 89% of abortion-related mortality from 2005-2007 (Stevens, 2012).

While previous studies have identified poor access to safe services and abortion stigma as the major drivers of unsafe abortion in South Africa today, these have yet to be adequately explored (Cooper et al., 2004; Gresh & Maharaj, 2014; Harries et al., 2015; Harries, Orner,

¹ In the context of South Africa, the term “Black” refers to all non-White racial groups while African refers to individuals of historically Bantu-speaking groups indigenous to Southern Africa (e.g., Xhosa and Zulu). In this paper, the terms African and Black African are used interchangeably so as to reflect language used in the studies or data cited.

Gabriel, & Mitchell, 2007; R. K. Jewkes et al., 2005; Orner, de Bruyn, & Cooper, 2011; Stevens, 2012; Trueman & Magwentshu, 2013). Briefly, abortion stigma can be understood as a negative, socially constructed label that is ascribed to women who access abortion care, abortion providers, and others associated with abortion (Harris, Debbink, Martin, & Hassinger, 2011; Kumar, Hessini, & Mitchell, 2009; B. G. Link & Phelan, 2001; Norris et al., 2011). Abortion attitudes (i.e., individual level abortion stigma) have yet to be analyzed from a nationally representative sample in South Africa, however, and it remains unclear if any differences exist by race and SEP or if they have changed over time. Further, while abortion access is annually monitored as the percent of licensed clinics currently providing abortions (Health Systems Trust, 2015), researchers have not fully explored whether access is related to abortion stigma or in what ways unsafe abortion might be patterned by gender, race, SEP, and HIV inequities. Further, research on abortion stigma and poor access to services has focused primarily on mechanisms at the individual level (e.g., fear of discrimination, lack of funds to pay for abortion). Additional investigations are needed to further examine processes that unfold at the structural (i.e., social, policy, and institution) level.

Evidence on abortion stigma in South Africa is generally derived from purely qualitative research and subpopulation, non-representative surveys that emphasize individual-level attitudes and perceived norms. For example, Gresh and Maharaj (2014) recently conducted one qualitative study among female university students in Durban, South Africa (N=20) where strongly negative attitudes toward abortion were often framed in religious, cultural, or moral rhetoric (e.g., “abortion as murder” or unchaste) (Gresh & Maharaj, 2014, p. 685). Women’s attitudes became ambivalent, however, when considering specific circumstances of unintended pregnancy such as rape. Similarly, Ronco’s (2014) Master’s thesis on the discursive constructs of abortion among

university students (two gender-specific focus groups; N=11) found that attitudes were generally more negative than positive, varied by circumstance, and were largely similar across gender groups. One exceptional study was a mixed methods investigation by Varga (2002), who conducted focus groups, role playing, in-depth interviews, and a survey—yet her investigation was focused on adolescents in KwaZulu-Natal and not other ages or regions. In general, participants reported women feel they have to keep their abortion secret and, therefore, often resort to self-induction or use of “backstreet” clinics (Varga, 2002 p. 289). Participants also alluded to a deep connection between abortion stigma and local context, including intense stigma against adolescent and extramarital childbearing in South Africa. Varga (2002) noted that women’s abortion decisions involved a context-specific balance between attitudes and socioeconomic limitations: poverty and one’s inability to mother due to socioeconomic limitations (e.g., child care) were often illuminated as major drivers of abortion.

While most studies fail to move past such individual-level analyses, Macleod and colleagues (2011) conducted an illuminating qualitative study of culture and public discourse surrounding abortion among three villages in the Transkei, a former African homeland. Through discourse analysis of eight gender-specific focus groups using fictional abortion vignettes, they found notable contradictions and conditional acceptance of abortion. The concepts of “culture,” “values,” “religion,” and “nation” were commonly evoked to oppose abortion (Macleod, Sigcau, & Luwaca, 2011, p. 240). Notably, several participants specifically appealed to “Black culture” saying abortion “is for white people. It came with white people...By allowing abortion the government is going to destroy our values. We have lost our traditions and customs and this is leading to disaster” (Macleod et al., 2011, p. 241). The researchers warn, however, that such appeals to “culture” erase pre-colonial abortion traditions among indigenous South African

groups, essentialize culture as homogenous and static, and often serve to bolster existing gender and intergenerational power structures. Historical research suggests abortion practices were common, widespread, and female-driven throughout pre-colonial South Africa and that these practices shifted dramatically through the colonial and Apartheid eras toward male- and White-dominated industries (Bradford, 1991; Hodes, 2013; Klausen, 2015). Future studies might, therefore, consider racial and socioeconomic differences in abortion stigma and whether stigma in African communities might constitute resistance against colonial ideologies wherein their culture and fertility was historically devalued and discouraged (Bradford, 1991; Frederickson, 1982; Hodes, 2013).

Study Objective and Research Questions

The first component of a broader mixed methods dissertation, the current paper aims to examine the associations between abortion attitudes, race, and SEP in a nationally representative sample of South African residents. More specifically, this study asks: A) How prevalent are negative attitudes toward abortion in contemporary South Africa? B) Are there significant differences in abortion attitudes by race? And C) Are there significant differences in abortion attitudes by household income or level of educational attainment?

Theoretical Framework: Reproductive Justice and Fundamental Causes Theory

Novel theoretical approaches are needed to further explore unsafe abortion inequities in South Africa and the specific roles of stigma and access therein. To date, research has utilized a limited reproductive rights framework that emphasizes women's universal human right to safe abortion care (de Bruyn, 2012; Guttmacher, Kapadia, Naude, & de Pinho, 1998; Lomelin, 2013; Trueman & Magwentshu, 2013; United Nations Population Fund (UNFPA), 1995; Varkey & others, 2000). This framework and the related pro-choice movement have been previously

criticized, however, for marginalizing women of color and of lower SEP while emphasizing “individualist, consumerist notions of ‘free’ choice that do not take into consideration all the social, economic, and political conditions that frame the so-called choices women are forced to make” (Davis, 2003; Luna & Luker, 2013; Smith, 2005, p. 127). In turn, abortion researchers in South Africa have yet to fully investigate how abortion is contextualized by women’s intersecting gender, racial, socioeconomic, and HIV-related identities; how barriers manifest from the individual to structural ecological levels; or why African women of lower SEP living with HIV are placed at disproportionate risk.

Reproductive justice offers a well-suited intersectional (Schulz & Mullings, 2006) and ecological (Sallis, Owen, & Fisher, 2008) framework for researching unsafe abortion inequities by expanding the traditional paradigm of reproductive rights to include having a child, not having a child, and parenting “healthily and with dignity” regardless of racial or socioeconomic background (Davis, 2003; Fried, Ross, Solinger, & Bond Leonard, 2013; Luna & Luker, 2013, p. 328; Roberts, 1998; Ross, 2006). In the mid-1990s, reproductive justice emerged as a grassroots social movement in reaction to the reproductive rights and pro-choice campaigns, which were led by and focused on White, affluent women primarily advocating for increased access to birth control and safe abortion (Davis, 2003; Fried, Ross, Solinger, & Bond Leonard, 2013; Luna & Luker, 2013; Roberts, 1998; Ross, 2006). In contrast, the reproductive justice movement centered experiences of gender, racial, and socioeconomic marginalization that strip away some women’s rights to safely conceive and mother their own children in *addition* to their right to safe abortion (Davis, 2003; Fried, Ross, Solinger, & Bond Leonard, 2013; Luna & Luker, 2013; Roberts, 1998; Ross, 2006).

Reproductive justice effectively builds upon the concepts of intersectionality (Crenshaw,

1989; Schulz & Mullings, 2006) and stratified reproduction (Colen, 1995) by acknowledging that gender, race, and SEP are mutually constructed and reinforced while social expectations of reproduction are, in turn, patterned by those gender, race and socioeconomic constructs and the ideologies behind them (i.e., sexism, racism, and socioeconomic inequity). The concept of intersectionality (Crenshaw, 1989) identifies gender, race, and SEP as inherently relational, “socially constructed categories [that] vary as a function of each other” in specific local contexts (Bowleg, 2012; Schulz & Mullings, 2006, p. 5). For example, normative definitions of motherhood are distinct by race, socioeconomic status, and geography, which carries important implications for abortion in South Africa. Applying intersectionality to public health, Schulz and Mullings (2006) emphasized that the (intersections of) sexism, racism, and SEP shape access to social and physical resources through a variety of pathways from the individual to structural levels. Reproductive justice also reflects Colen’s (1995) anthropological theory of stratified reproduction, which refers to “the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (Ginsburg & Rapp, 1995, p. 3). Stratified reproduction has previously been used to explain the South African context and patterns of unsafe abortion—but never the topics together.

In public health and population studies more specifically, researchers have previously conceptualized SEP/socioeconomic inequity (Baker, 2010; Coburn, 2004; Diez Roux, 2012; House & Williams, 2000; B. Link & Phelan, 1996; J Lynch, 2000; McIntyre & Gilson, 2002; Williams, Mohammed, Leavell, & Collins, 2010), race/racism (Charasse-Pouélé & Fournier, 2006; Diez Roux, 2012; House & Williams, 2000; Phelan & Link, 2015; Williams et al., 2010), and gender/sexism (Iyer, Sen, & Östlin, 2008; Kehler, 2001; Ostlin, George, & Sen, 2003) as "fundamental causes" of poor reproductive health outcomes globally and in South Africa,

specifically. Operating through multiple and ever-shifting pathways, fundamental factors affect virtually all structural-level environments *and* individual-level psychosocial factors including access to health services and individual attitudes. Socioeconomic inequity specifically refers to the unequal allocation of flexible resources such as money, education/knowledge, and power that can be utilized to improve health—it is dynamic, multi-faceted, intergenerational, and inherently relational nature (Coburn, 2004; Diez Roux, 2012; Kehler, 2001; Krieger, Williams, & Moss, 1997; Leibbrandt, Poswell, Naidoo, Welch, & Woolard, 2006; J Lynch, 2000; John Lynch & Kaplan, 2000; J. W. Lynch, Smith, Kaplan, & House, 2000; Statistics South Africa, 2014). I am using the definition of SEP that acknowledges both one's individual-level place in a socioeconomic hierarchy and the structural processes (e.g., underinvestment in social infrastructure) and background factors (e.g., history, culture, social inequity) that create real-life living conditions (Coburn, 2004; J. W. Lynch et al., 2000, p. 1205). Further, researchers have demonstrated that race and racism significantly account for health inequities above and beyond SEP in numerous global settings including post-Apartheid South Africa (Charasse-Pouélé & Fournier, 2006; House & Williams, 2000; Phelan & Link, 2015; Williams et al., 2010). I use the conceptualization of racism as a system of hierarchical stratification based on socially constructed categories of so-called “race” despite scientific evidence that has debunked biological differences by racial category (Bassett, 2000; Charasse-Pouélé & Fournier, 2006; Phelan & Link, 2015). While scientists largely agree race has no biological basis, powerful social constructions of race have real consequences that shape social experiences, access to resources, and exposures to risk—all of which carry implications for health and wellbeing (Frederickson, 1982; Roberts, 2013, 2014; Schulz & Mullings, 2006). Finally, I also define gender as a purely social institution, structure, and stratification process through which particular activities, roles,

privileges, and characteristics are associated with a given biological sex (Cook, 1995, p. 353; Lorber, 2007; Ostlin et al., 2003). Gender is constructed by sexism, a system of social oppression characterized by “male-dominated, male-identified, and male-centered” patriarchy (Johnson, 2005, p. 5). Notably, gender, race, and SEP do not operate in isolation, but rather intersect in complex and unique ways that pattern the distribution of risk factors (including HIV), protective resources, and health outcomes as previously described (Schulz & Mullings, 2006; Williams et al., 2010).

Data and Research Methods

The current study investigates abortion attitudes from a nationally representative sample (N=2,885) in South Africa using data from the most recent South African Social Attitudes Survey of 2013 (Human Sciences Research Council, 2015). This is a nationally representative, face-to-face survey conducted annually and sampled from 500 census enumeration areas stratified by province, urbanicity, and race (Human Sciences Research Council, 2015). Descriptive statistics of the weighted sample from 2013 are presented in Table 1. Dependent variables of interest were attitudes about abortion in the case of severe fetal defect and attitudes about abortion in the case a family is low-income. Descriptive statistics on the dependent variables are provided in Table 2. Bivariate analyses using chi-squared statistics and sample weighting are presented in Table 3. Binary logistic regression models were estimated using sample weighting and are presented in Tables 4 and 5. Abortion attitudes were first estimated by relevant socio-demographic variables including sex, age, religiosity, political ideology, gender, race, and socioeconomic equity attitudes, urbanicity, and province. Race was then added to the model in order to estimate the effects of race above and beyond other socio-demographic characteristics. Socioeconomic indicators (educational attainment and household income) were

added to the model in order to estimate the effects of SEP above and beyond other factors including race. Finally, stratified models were estimated separately for each racial and educational subgroup as shown in Tables 6 and 7. All analyses were conducted in Stata v. 14 (StataCorp, 2014).

Preliminary Results

When asked about abortion in the case of serious fetal defect, 63.1% of South Africans surveyed said it was Always Wrong (54.6%) or Almost Always Wrong (8.5%). When asked about abortion in the case a family is low income and cannot afford a child, 83.6% of South Africans surveyed said it was Always Wrong (75.4%) or Almost Always Wrong (8.2%).

Bivariate analyses revealed that several hypothesized socio-demographic predictors are significantly related to abortion attitudes in addition to covariates previously identified in the empirical literature (see Table 3). Negative abortion attitudes in the case of serious fetal defect were associated with race ($\chi^2= 34.4, p<.001$), lower educational attainment ($\chi^2= 36.2, p<.001$), and lower household income ($\chi^2= 28.99, p<.01$). When bivariate analyses were conducted with the dummy race variables, only being White ($\chi^2=5.3, p=.07$) was marginally associated with negative abortion attitudes (results not shown but available on request). Negative abortion attitudes in the case of serious fetal defect were also significantly associated with age ($\chi^2= 59.9, p<.01$), attitudes toward gender ($\chi^2= 40.6, p<.001$), racial ($\chi^2= 59.7, p<.001$), and socioeconomic equity ($\chi^2= 28.0, p<.001$), and province ($\chi^2= 125.6, p<.001$). Negative abortion attitudes in the case of family poverty were significantly related to lower educational attainment ($\chi^2= 44.1, p<.001$), but race ($\chi^2= 5.34, p=.20$) and household income ($\chi^2= 6.90, p=.27$) were not associated with attitudes in bivariate analyses. Several significant covariates were identified: attitudes toward gender ($\chi^2= 24.3, p<.001$) and racial equity ($\chi^2= 11.9, p<.05$), urbanicity ($\chi^2=$

19.2, $p < .05$), and province ($\chi^2 = 132.8$, $p < .001$). Being female and older respondents were marginally more likely to report negative abortion attitudes.

Step-wise binary logistic regression models were run on the two abortion attitudes separately (see Tables 5 and 6). Negative attitudes toward abortion in the case of severe fetal defect was significantly predicted by lower educational attainment (OR: 0.78, $p < .05$) above and beyond the effects of race and relevant covariates. Race was significantly associated with negative abortion attitudes (OR: .82, $p < .05$) until socioeconomic indicators were included in the model (OR: .92, $p = .46$). Household income was not associated with abortion attitudes. Province was a significant predictor (OR: 1.16, $p < .001$). Using Northern Cape as a reference (where abortion attitudes most closely approximated the national profile), respondents from the Eastern Cape (OR: .45, $p < .01$), Western Cape (OR: .54, $p < .05$), Mpumalanga (OR: .53, $p < .05$) and KwaZulu-Natal (OR: .51, $p < .05$) reported significantly more positive attitudes, while respondents from Limpopo (OR: 1.99, $p < .05$) reported significantly more negative attitudes.

In the case a family is low income and cannot afford a child, negative attitudes toward abortion were significantly predicted by lower educational attainment (OR: 0.71, $p < .05$) above and beyond the effects of race and relevant covariates. Race was not significantly associated with negative abortion attitudes (OR: 1.05, $p = .71$) nor was household income (OR: 0.91, $p = .57$). Being female marginally predicted higher odds of negative abortion attitudes (OR: 1.48, $p = .07$) and province was a significant predictor (OR: 1.23, $p < .001$). Using KwaZulu-Natal as the reference (where abortion attitudes most closely approximated the national profile), respondents from the Eastern Cape (OR: .48, $p < .05$) and Western Cape (OR: .31, $p < .001$) were significantly more tolerant of abortion in the case of poverty. Those in the Free State (OR: 3.54, $p = .01$) expressed significantly more negative attitudes.

Additional models for both abortion attitudes were run using dummy variables for each racial category, exchanging the referent category to explore all possible pair-wise racial comparisons (e.g., White-African, Coloured-Indian). None of these analyses identified any significant racial differences in abortion attitudes (results not shown but available upon request).

Binary logistic regression models were run separately for each racial group to discern significant differences in the model of abortion attitudes across groups (see Tables 6A and 6B). Preliminary results suggest negative abortion attitudes in the case of severe fetal defect are predicted by lower household income among Black African respondents (OR: .77, $p < .05$) but by *higher* household income among Indian/Asian respondents (OR: 2.2, $p < .05$). Lower educational attainment is marginally associated with negative abortion attitudes among Black African (OR: .79, $p < .1$) but not Coloured, Indian/Asian, or White respondents. In the case a family is low income, negative abortion attitudes are predicted by lower educational attainment among Black African respondents (OR: .71, $p < .05$) and Indian/Asian respondents (OR: .31, $p < .01$). Lower household income is associated with negative abortion attitudes among White respondents (OR: .26, $p < .05$) only. Control variables included in the models were sex; age; religiosity; political ideology; attitudes toward gender, racial, and economic equity; urbanicity; and province.

Binary logistic regression models were also run separately for each education subgroup to discern significant differences in the model of abortion attitudes across socioeconomic groups (see Tables 7A and 7B). Preliminary results suggest negative abortion attitudes in the case of severe fetal defect are marginally predicted by lower household income among respondents with some secondary education (OR: .71, $p < .1$). Significant covariates included province for all education levels, racial equity attitudes for those with some secondary education (.78, $p < .05$), religion for respondents with some tertiary education (OR: .76, $p < .001$), and being female for

those with primary education or less (OR: 1.91, $p < .001$). In the case a family is low income, negative abortion attitudes are not significantly predicted by race or household income when groups are separated by education level. Significant covariates of negative abortion attitudes included province for those with less than tertiary education; racial (OR: 0.77, $p < .1$) and economic equity (OR: 0.71, $p < .05$) attitudes for those who completed secondary education, conservative political ideology (OR: 1.18, $p < .1$) for those with less than a secondary education, and being female for those with tertiary education (OR: 3.4, $p < .01$). Control variables included in the models were sex; age; religiosity; political ideology; attitudes toward gender, racial, and economic equity; urbanicity; and province.

The fit of both logistic regression models was quite poor as reflected by BIC and pseudo- R^2 statistics (results not shown but available upon request). Additional posthoc analyses are needed for additional comparison across race- and education-specific models.

Preliminary Conclusions

Overall, preliminary results from the current study suggest that negative attitudes toward abortion, particularly in the case of maternal poverty, are very common in South Africa. This suggests there remains significant abortion stigma despite the country's progressive legal abortion environment. While these data only reflect individual-level attitudes, they carry potential implications for abortion stigma at the interpersonal, institutional, community, and policy levels. This is especially true among groups that seem to report more negative abortion attitudes. In particular, individuals of lower SEP (i.e., lower educational attainment) are more likely to report that abortion is almost always wrong/always wrong in the cases of severe fetal defect and maternal poverty as are those living in certain provinces (Limpopo, Free State)—although the close-ended survey questions and answer choices are notably limited. Provincial

differences likely reflect unmeasured ethnic heterogeneity within racial groups as well as variance in provincial-level abortion policy and institutional contexts. It is possible that pregnant women of lower educational attainment or living in those particular provinces will experience increased abortion stigma and related barriers if attempting to access termination of pregnancy services. Interventions to diminish abortion stigma and improve access to safe abortion services might focus on these vulnerable groups.

These results contribute to the existing literature on global abortion stigma. Stigma has been defined as a “deeply contextual, dynamic social process” (Norris et al., 2011, p. S49) that is inherently relational and entirely contingent upon social inequity (B. G. Link & Phelan, 2001). In the words of Link and Phelan (2001, p. 375), “it takes power to stigmatize.” In turn, the degree of stigma experienced by different groups often varies, which researchers suggest is a reflection of power differentials between social groups (Kumar et al., 2009; B. G. Link & Phelan, 2001; Norris et al., 2011). In their transformative piece “Conceptualising Abortion Stigma,” Kumar, Hessini, and Mitchell (2009) first described the cyclical prevalence paradox. They posited that abortion stigma rises from non-conformity with social expectations of womanhood including inevitable motherhood, the feminine instinct to nurture, and female sexuality as solely for procreation; personification of the fetus; legal restrictions against abortion; and beliefs that abortion is unhealthy (Kumar et al., 2009; Norris et al., 2011). Like stigma generally, abortion stigma is not universal or inherent to human nature. Rather, it is constructed and reinforced through social processes in specific local contexts characterized by inequitable social access to power and resources (Kumar et al., 2009; Norris et al., 2011). Kumar and colleagues (2009) originally situated abortion stigma and its consequences for women within an encompassing ecological model (individual, community, institutional, policy, and social/discourse levels). Such

stigma carries direct implications for abortion-related human resources (e.g., availability of abortion providers, staff burnout, employee cohesion) in addition to the psychological and physical wellbeing of providers.

Our results expand on this literature by investigating more deeply the potential differences in abortion stigma that exists among racial and socioeconomic subgroups in South Africa. These findings could help explain observed disparities in unsafe abortion for Black African women of lower SEP. Acknowledging limited subsample size and the need for ongoing analysis and interpretation, a number of preliminary conclusions can be reached. First, socioeconomic factors (i.e., educational attainment and household income) appear to significantly affect abortion attitudes across racial groups and regardless of the circumstances of abortion (i.e., fetal defect or poverty). Second, province emerged as a significant predictor of abortion attitudes within racial and socioeconomic subgroups just as it did in the overall national sample. This suggests underlying heterogeneity across not only ethnic groups (e.g., differences between Xhosa and Zulu Black African groups) but also provincial-level contexts (e.g., abortion policy, social policy) that must be further explored. Third, covariates of abortion attitudes identified by previous studies are most influential among White respondents. This suggests that our understanding of abortion-related attitudes to date likely reflect underlying assumptions based on White-centric ideology, study samples, and research protocols. The theoretically derived model used in the current study did not predict the majority of variance, particularly for non-White respondents, which could also reflect limited underlying variance due to the skewed nature of our dependent variables. Further studies are needed to assess if a different operationalization of the dependent variables (i.e., Always Wrong vs. all other answer responses)

would improve the analysis. Additional research is also needed to identify additional predictors of abortion attitudes, particularly within non-White communities.

Despite the strong evidence for continuing social disapproval of abortion in South Africa, these preliminary analyses have also identified a number of protective factors against abortion stigma, which could be investigated to better understand how positive abortion attitudes are cultivated. First, increasing educational attainment is independently related to more positive abortion attitudes. This suggests that continuing investment in secondary and post-secondary education for South Africans will result in increasing tolerance of abortion. This could manifest as decreased interpersonal and community stigma, increased number abortion providers, and improved policy environments. Second, while a number of provinces demonstrated particularly negative attitudes toward abortion, the Eastern Cape and KwaZulu-Natal serve as powerful counter-examples where abortion under various circumstances is more tolerated.

The results presented in this paper provide an initial investigation into abortion-related attitudes from a nationally representative sample. All conclusions are based on cross-sectional data and, therefore, represent statistical associations and not causal linkages. Concerns of sample size are apparent, particularly when stratifying models by race. Further studies might need to aggregate multiple surveys in order to increase the samples of racial subgroups. Interaction terms might also be used to maximize available sample sizes, and this would be particularly appropriate for an intersectional, reproductive justice framework. Additionally, the questions used to measure abortion attitudes were close-ended and do not fully or clearly capture the full spectrum of abortion ideologies. Further studies are needed to further investigate the identified differences by province and education—for example, by including language spoken at home as a proxy of ethnicity. Moreover, while each of the regression models were statistically significant,

they did not explain the majority of variance in abortion attitudes. Additional posthoc analyses are needed to discern significant differences across racial and socioeconomic subgroups.

Continuing research is needed to better understand what creates abortion attitudes and stigma, particularly in groups at high risk of abortion-related mortality.

Broader limitations of quantitative data on abortion in South Africa must be acknowledged and considered by future studies. These include the incompleteness and misclassification of abortion data (Stevens, 2012; Trueman & Magwentshu, 2013) and the problematic post-Apartheid conventions of “color blindness” (Bassett, 2000). For example, race-specific data on abortion procedures and abortion-related deaths are not collected or reported at the national level. Further, the dynamic interplay between access and stigma is likely much more complicated than researchers have previously documented using national monitoring systems (e.g., percent of licensed facilities offering abortion services). While theorists have posited that abortion stigma manifests in a multitude of structural and individual-level ways, they also warned that thorough understanding requires close examination of local contexts and the limits of stigma. Future studies must deeply explore processes through which abortion stigma affects access to abortion services and how access to abortion services may be unrelated to stigma. In other words, it remains unclear how, if at all, accessibility of abortion services reflects broader limitations of the South African health system—for example, privatization and increasing costs of services or understaffing at public clinics. Further studies might include attitudes toward healthcare, generally, as reported on SASAS. Additionally, while evidence suggests unsafe abortion is more common among Black African women of lower SEP living with HIV in South Africa, it remains unclear how unsafe abortion becomes patterned by social inequities. Results from our study would suggest racial differences in abortion stigma cannot account for racial

inequities in unsafe abortion. Socioeconomic inequity might explain some unsafe abortion disparities if those women of lower educational attainment both harbor their own negative attitudes toward abortion or perceive stigma from their fellow community members. While respondent sex was not identified as a significant predictor of abortion attitudes in the current study, experiences of abortion cannot be separated from broader ideologies related to womanhood. Finally, the role of HIV and HIV stigma in abortion attitudes and access to safe abortion remains unclear and cannot be answered with existing quantitative data. Such questions can best be investigated through in-depth qualitative data collection and analysis in sub-national South African contexts.

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TablesTable 1. Abortion Attitudes in a 2013 Nationally Representative South African Sample¹

Category		Percent	
<i>Binary Value</i>	<i>Ordinal Value</i>	<i>Serious Defect</i>	<i>Poverty</i>
Generally Positive	Not Wrong At All	22.5	9.1
	Wrong Only Sometimes	14.1	7.3
Generally Negative	Almost Always Wrong	8.5	8.2
	Always Wrong	54.6	75.4

¹ All percentages shown are from the weighted sample.

Table 2. Descriptive Statistics of a 2013 Nationally Representative South African Sample

Variable	Value	Percent
Race	Black African	77.8
	Coloured	9.2
	White	10.2
	Indian/Asian	2.8
Educational Attainment	Primary or Less	18.3
	Some Secondary	40.1
	Matric or Equivalent	31.5
	Tertiary Education	10.2
Household Monthly Income	R1500 or Less	32.8
	R1501-R50,000	39.5
	R50001+	27.7
Sex	Female	51.9
	Male	48.1
Age	<20	10.3
	20-24	14.5
	25-29	13.2
	30-34	12
	35-39	11.2
	40-44	8.6
	45-49	6.7
	50-54	6
	55+	17
Religion	Christian	69.5
	Not Religious	15

	Other	11.5
	Muslim	2.7
	Jewish	0.2
Political Ideology	Extremely Liberal/Left	8.5
	Liberal/Left	13.3
	Don't Know	25
	Moderate	23.9
	Conservative/Right	7.5
	Extremely Conservative/Right	3.3
Gender Equity Attitude	Strongly Disagree	5.6
	Disagree	12
	Neither Disagree/Agree	14.9
	Agree	43.8
	Strongly Agree	23.8
Racial Equity Attitude	Strongly Disagree	10
	Disagree	10.9
	Neither Disagree/Agree	14.5
	Agree	35.8
	Strongly Agree	28.8
Economic Equity Attitude	Strongly Disagree	3.2
	Disagree	15.3
	Neither Disagree/Agree	10.1
	Agree	46.8
	Strongly Agree	24.7
Urbanicity	Formal Urban	63.5
	Traditional Authorities	24.6
	Informal Urban	9.1
	Rural (Formal)	2.7
Province	Gauteng	26.2
	KwaZulu-Natal	18.6
	Western Cape	11.9
	Eastern Cape	11.8
	Limpopo	9.9
	Mpumalanga	7.5
	North West	6.7
	Free State	5.3
	Northern Cape	2.2

Table 3. Bivariate Analyses of Abortion Attitudes in a 2013 Nationally Representative South African Sample

Variable	<i>Serious Defect</i>		<i>Poverty</i>	
	χ^2	p-value	χ^2	p-value
Race	34.40 ***	<.001	5.34	0.20
Educational Attainment	36.17 ***	<.001	44.05 ***	<.001
Household Income	28.99 **	<0.01	6.90	0.27
Sex	6.04	0.11	8.50 †	0.06
Age	59.87 **	<.01	36.89 †	0.06
Religious Category ¹	5.98	0.72	5.87	0.74
Political Ideology	12.49	0.56	24.97	0.13
Gender Equity Attitude	40.61 ***	<.001	24.33 ***	<.001
Racial Equity Attitude	59.71 ***	<.001	11.88 *	<.05
Economic Equity Attitude	27.98 ***	<.001	4.70	0.32
Urbanicity	11.19	0.15	19.16 *	<.05
Province	125.64 ***	<.001	132.75 ***	<.001

Note: † p<.1, * p<.05, ** p<.01, *** p<.001

¹Sensitivity analyses performed with Religion as a multinomial variable including Christian denominations together and separate as well as a binary variable for religiosity. Results were similar throughout.

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Table 4. Binary Logistic Regression of Abortion Attitudes in the Case of Serious Fetal Defect in a 2013 Nationally Representative South African Sample

Variable	<i>Model 1</i> ***		<i>Model 2</i> ***		<i>Model 3</i> ***	
	Odds Ratio	p	Odds Ratio	p	Odds Ratio	p
Female	1.25 †	0.09	1.26 †	0.082	1.27	0.126
Age	1	0.836	1	0.49	1	0.883
Religion	1.02	0.682	1.02	0.737	0.96	0.505
Political Ideology	1.01	0.846	1	0.921	0.99	0.859
Gender Equity Attitude	1.03	0.692	1.01	0.927	1	0.987
Racial Equity Attitude	1.04	0.501	0.98	0.714	0.89	0.12
Economic Equity Attitude	1.11 †	0.094	1.09	0.169	1.05	0.513
Urbanicity	1.07	0.361	1.03	0.726	0.95	0.585
Province	1.13 ***	<.001	1.13 ***	<.001	1.16 ***	<.001
Race			0.82 *	<.05	0.92	0.463
Educational Attainment					0.78 *	<.05
Household Income					0.81 †	0.074

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Table 5: Binary Logistic Regression of Abortion Attitudes in the Case a Woman is Low Income in a 2013 Nationally Representative South African Sample

Variable	<i>Model 1 ***</i>		<i>Model 2 ***</i>		<i>Model 3 ***</i>	
	Odds Ratio	p	Odds Ratio	p	Odds Ratio	p
Female	1.36 †	0.08	1.37 †	0.08	1.48 †	0.07
Age	1.01 *	0.036	1.01 *	0.02	1	0.58
Religiosity	0.99	0.845	0.99	0.82	0.96	0.56
Political Ideology	0.99	0.75	0.99	0.73	1.04	0.39
Gender Equity Attitude	0.97	0.7	0.96	0.6	0.89	0.22
Racial Equity Attitude	0.98	0.8	0.95	0.5	0.91	0.29
Economic Equity Attitude	1.1	0.25	1.08	0.3	1	0.99
Urbanicity	1.25	0.02	1.23 *	<.05	1.08	0.54
Province	1.17 ***	<.001	1.17 ***	<.001	1.23 ***	<.001
Race			0.9	0.278	1.05	0.71
Educational Attainment					0.71 *	<.01
Household Income					0.91	0.57

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Tables 6A and 6B. Race-Specific Models of Abortion Attitudes in the Case of Severe Fetal Defect (A) or Poverty (B) in a 2013 Nationally Representative South African Sample

Abortion In the Case of Severe Fetal Defect	Black African	Coloured	Indian/Asian	White
	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Female	1.34	0.58	0.51	1.13
Age	1	0.99	1	0.98
Religiosity	0.96	0.94	0.78	1.26
Political Ideology	0.97	1.11	1.05	1.2
Gender Equity Attitude	1	0.93	0.95	1.18
Racial Equity Attitude	0.89	1.26	0.87	0.74
Economic Equity Attitude	1.05	1.18	1.31	1.09
Urbanicity	0.92	1.44 †	40.79 ***	omitted
Province	1.22 ***	1.05	1.66 *	0.91
Educational Attainment	0.79 †	0.91	0.74	0.69
Household Income	0.77 *	0.71	2.2 *	1.11

Abortion In the Case of Poverty	Black African	Coloured	Indian/Asian	White
	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Female	1.55 †	0.59	0.74	2.14
Age	1.01 †	0.98 †	0.98	0.96 *
Religiosity	0.95	0.97	0.95	1.48
Political Ideology	1.03	1.08	0.87	1.46 *
Gender Equity Attitude	0.88	0.81	1.53	1.2
Racial Equity Attitude	0.93	1.1	0.8	0.59 *
Economic Equity Attitude	0.92	1.24	1.03	1.67 *
Urbanicity	1.05	1.12	omitted	omitted
Province	1.3 ***	1.01	1.52 *	0.93
Educational Attainment	0.71 *	0.92	0.31 **	1.03
Household Income	0.9	0.8	2	0.26 *

Tables 7A and 7B. Tables 6A and 6B. Education-Specific Models of Abortion Attitudes in the Case of Severe Fetal Defect (A) or Poverty (B) in a 2013 Nationally Representative South African Sample

Abortion In the Case of Severe Fetal Defect	Primary or Less	Some Secondary	Completed Secondary	Some Tertiary
	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Female	1.91 *	1.1	1.13	1.3
Age	1.01	1.01	1	0.98
Religiosity	0.87	0.95	1.17	0.76 ***
Political Ideology	0.98	0.97	1.08	0.87
Gender Equity Attitude	0.95	1.14	0.96	0.97
Racial Equity Attitude	1.05	0.78 *	0.9	0.86
Economic Equity Attitude	1.21	0.9	1.08	1.16
Urbanicity	1.03	1	0.84	1.57
Province	1.15 *	1.19 ***	1.24 ***	0.94 ***
Educational Attainment	1.25	0.86	0.95	0.75
Household Income	0.8	0.71 †	0.9	1.03

Abortion In the Case of Poverty	Primary or Less	Some Secondary	Completed Secondary	Some Tertiary
	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Female	1.12	1.38	1.29	3.4 **
Age	1.01	1	1	1.01
Religiosity	0.98	0.91	0.99	0.88
Political Ideology	1.18 †	1.04	1.01	0.85
Gender Equity Attitude	0.84	0.82	0.88	1.07
Racial Equity Attitude	1.27	0.96	0.77 †	0.86
Economic Equity Attitude	1.14	1.14	0.71 *	1.41
Urbanicity	1.06	0.85	1.46 †	1.07
Province	1.28 *	1.36 ***	1.19 *	0.96
Race	1.46	1.22	0.92	0.75
Household Income	0.68	0.7	1.19	1.57

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